Contesting Compulsory Mental Wellness:
Unwellness, design, and pedagogy in *Open in Emergency* as conduits for politics, negotiation, and new imaginaries

By

Maggie Mang

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Approved:

Aimi Hamraie, Ph.D.

Kenneth MacLeish, Ph.D.

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Introduction

"Witches, weirdoes, crazies, all: Take up your spells. We are going to war" (Thom, 12).

Unboxing

The cardboard box, not much smaller than a shoebox, sits in the corner of my room for months collecting dust. When I sit on my bed, I can easily see the red label on the side of the box, "AALR: A special Issue on Asian American Mental Health." When I walk back into my room, I can see the label on the other side call out to me in the same red invitation: "OPEN IN EMERGENCY," it reads. I leave it on my floor, unopened, for weeks.

When I finally get around to unboxing it, it's not in my room. It's in the back corner of the Divinity Library on campus, a quiet, neutral space that I need. I start first with the introductory note, written by guest editor Mimi Khúc. "Dear Elia," it starts. "Sometimes I think of killing myself." Those last six words hit me like a weight, and suddenly the world around me is eerily still and quiet, almost as if waiting with bated breath to see how I'll react.

I proceed forward, but not without dragging my feet, as I slowly begin unboxing the rest of the box in front of me. I start for a few seconds and then get intentionally distracted; I do this back-and-forth dance for at least an hour. I begin by flipping through the contributors' notes, which are full of beautiful, albeit brief, biographies of the project's contributors. The notes themselves are printed in a 4" x 6" pamphlet, a material lighthouse that shows just how many contributors gave to this project. They are numerous and expansive, these artists and academics and activists, these people who write and teach and dream. Flipping and reading, I get pangs of jealousy, strangely enough, a melancholic form of deep desire and the need for recognition that was not found by growing up in a predominantly white suburb outside of Tucson, Arizona, with few people who also identified the way that I did.

In the quiet of the library around me, I make slight rustling noises, as I unfold the large, testimonial tapestry, a 36" x 24" sheet of glossy paper meant to represent a literal, fiber arts tapestry. It takes four folds to reach the final product, a tapestry, indeed, of colors and shapes and visual textures and art. There is a sketch of a Sikh man in the middle, an image of a bird made through printmaking in the top left. I have to turn the gigantic tapestry different degrees, left and right and upside down, to read some of these contributions. I am lucky that I am sitting at a large table that can hold the size of this paper, because I am not sure that I can hold everything that these contributors are speaking to.

Esther Lee's rectangle first catches my eye, a rougher-textured orange rectangle made up of three stitched-together pieces on material that resembles the texture of a sponge. The first two parts read: "1. how do i tell / this story / without outsiders / reshaping it into / a tiger mother tale? 2. my unhealed / abc mother groomed / and fed my despair along / with my high-achievement and my / sense of womanhood. what she was grooming me into felt like dying" (Lee, tapestry). How do I tell my own story through these lenses? A similar story of high-achievement and high-functionality being groomed into me to the point where it made me illegible to my undergraduate counseling center when I reached out for help. A similar story of a queer daughter who can't wear her leather jacket at home for fear of it being taken away and locked up. But how do I also, as Lee writes, tell these stories without others spinning it into a Tiger Mother story? Intergenerational trauma runs deep, and I bristle with confusion, anger, and sadness at the many internal paradoxes that come with recognizing this.

Judy Kawamoto's contribution is printed on top of what looks like a doily. "Good news," she writes. "After a long, persistent struggle by Asian American mental health professions to set the record straight, Asian people are finally less likely to be viewed as 'passive, overly dependent, quiet to the point of being thought of as stupid or up to no good" (Kawamoto, tapestry).[1] I feel embarrassed admitting that I do not know if Kawamoto writes this sarcastically. My own East Asian American therapist accused me of being collectivist when I had admitted to her that I felt guilty sitting in her office when I knew that there was a growing waitlist of students needing support, too. What I really needed to communicate to her, which I did not have the words to then, is that the narratives of mental health on a university campus, in conjunction with the available resources (always too few), co-constitute the contours of one's unwellness, the legibility of such, and its deservingness.[2] I also wanted to communicate to her that there were other factors that she needed to see as central, like family, nationality, race, gender, and sexuality, instead of attributing most of this malaise to being "just stress". I didn't go back after that.

I gently fold the tapestry back into its original shape, right over left, four times over. Even back in its folded form, the colors and textures and layers — cursive on fabric surrounded by stitches — peek out at me, vibrant as ever. My hands move to the next piece in the box, a white, sanitized, and medicalized pamphlet on post-partum depression, treated with the voices of four Asian American mothers.

The pamphlet looks like a mix between a scrapbook, with its washi tape pinning scraps of paper to the pamphlet; a professor's feedback on a midterm, with its red lines and circles starkly contrasting the white background; and classified documents, with its redacted, black Sharpied-out information. I read these women's testimonials. "The rate of PPD," writes Sharline Chiang, "likely has something to do with what a

society does or doesn't do to support mothers" (PPDP). This is in direct contrast to the original pamphlet, when it states, "Postpartum depression can affect any woman regardless of age, race, ethnicity, or economic status" (PPDP). But, contends Khúc, it is also imperative to note that women are differentially at risk due to the stresses and pressures that come from structural violence and structural inequity, the lack of support structures, the absence of recognition of parenting as labor.

I think about additional documents, pamphlets, and brochures that circulate within the confines of the clinic that could benefit from being treated in the same way. I imagine the numerous amounts of documents that purport a homogenized version of unwellness and reveal no room for contestation, modification, or negotiation. I, too, have often read that mental illness can affect anyone regardless of age, gender, or race. While I see the merits of attempts to demoralize mental illness, what these accounts then eclipse are the ways in which people are made differentially unwell and at risk through structures of inequity.

The next items in the box are found in an envelope. True to this container, inside can be found ten letters written from daughters to mothers. My heart immediately grows heavy and I am quickly transported to Merle Woo's own words to her mother, the very words that first catalyzed me to think more critically about my own East Asian American identity: "Dear Ma, I was depressed over Christmas, and when New Year's rolled around, do you know what one of my resolves was? Not to come by and see you as much anymore. I had to ask myself why I get so down when I'm with you, my mother, who has focused so much of her life on me, who has endured so much; one who I am proud of and respect so deeply for simply surviving" (Moraga and Anzaldúa, 2015).[3]

Reading these letters in the depths of the library moved my heart in ways I don't quite have words to articulate. Some of the handwriting is more legible than others. Some are typed. One is written in a way where I have to rotate the paper in an effort to read what it says. All draw on their experiences in navigating relationships with their mothers. Some evoke feelings of gratitude. Others struggle with talking about their mental health to family members who may not understand. Still others grapple with the tensions of intergenerational trauma, of the gravity that comes with what Khúc calls the "civilizing terror that is model minoritization" (Khúc, editor's note). I am thrown, in that moment, to the first time I tried to put my own lived experiences to words, an attempt that manifested in the spring of 2018 in a letter to my own mother, inspired by Woo's work. "I know that there is this disconnect between us, one that has existed between us for some time now," I wrote, almost a year ago. "It feels like an ocean, an entire generation, an entire cultureanentirelanguageandmanyentirehistories between us."

I pull out the small, light-blue box next. Not without some difficulty given the design of the box, I pry open the two layers and pull out the Tarot cards. There are 23 cards in total, all of which have beautiful and provocative art printed on the front, all from different artists and contributors. The cards are printed on cardstock, so the weight feels heavier than a normal deck of cards. Their size, too, are a little larger than playing deck cards. The back alternates between yellow and blue backgrounds, each with their own descriptions that also come from different contributors. Because of this, there is no uniform writing or aesthetic theme that runs throughout the cards. However, I don't think that there needs to be, either, for there are various different ways in which being Asian American might look like and feel like; the diversity of the art and the writing reflect this.

I have never read Tarot before, so I look online for easy spreads for me to do. I settle on a one-card spread. "How do I reconcile with my queer, Asian-American identity?" I ask both myself and the empty room in front of me. I shuffle the deck three times and draw out a single card, revealing the seventeenth card in the major arcana, "The Refugee". The color palate of the card showcases soft, gentle colors, mixtures of baby blues and beige. The card shows boats, some empty, some with refugees inside, about to make land. A helicopter looms overhead.

"In a reading, the Refugee can signal a crisis requiring an intervention. But while crisis might intensity as a catastrophic event, the danger might well be an ongoing condition or structure," the card reads. "The Refugee warns that while the crisis might describe the limits of a condition or structure — even a habit of being in the world — the desire for security and protection can also recruit control or even submission" (Tarot, 17). My current situation where I have to lie about my queerness to my family certainly feels like an ongoing crisis. On the really bad days, I wish for the "security and protection" that the Tarot describes. However, what this Tarot reading importantly reminds me of is that this crisis, as well as its desire for the "security and protection [that] can also recruit control or even submission" is brought about because of ideological and structural boundaries that limit my own "being in the world." I adamantly do not desire compulsory heteronormativity and recognize that the heterosexism taken up within some of my communities reflect, as Mimi Thi Nguyen writes in this card, "obstacles to [my] own flourishing" (Tarot, 17).

Finally, my hands move to the DSM. Unlike the DSM used in psychiatric practice, a weighty book totaling about a thousand pages, this DSM found in OiE is different. It is thinner, 172 pages in total, with the words, "DSM: ASIAN AMERICAN EDITION" emblazoned in gold letters on the front. Not knowing how else to begin, I begin chronologically, with Kai Cheng Thom's *belief in mental illness*. "To be mentally healthy," writes Thom, "means to fit inside the confines of a job and heteronormative conceptions of sexuality/romance, to

uphold social conventions of race and class and gender" (DSM, 9). I sometimes tack back and forth in the degrees of my own self-loathing, my own feelings of failures that stem from falling short of subscribing to these dominant confines of what is "expected" of me: sometimes, an inability to work "hard enough" or to be "productive enough"; an inability to find a "nice boy" to "settle down with"; an inability to pursue a career that would carry with it a large enough paycheck to justify all the sacrifices made in the name of the "American Dream". The fear of deviating from these norms runs deep in a society where seemingly everything around us pressure us to normalize to the nth-degree. It was of no surprise, then, that my mother would ask me the two questions that pointed to her greatest fears: a) Am I depressed? and b) Was I gay?

And yet, reading through this DSM brought waves of relief, too, because for far too long, I had swallowed the ideological pill that if I were feeling unwell, it was solely because I wasn't doing enough to maintain my mental health, that I was too weak, that I should be "trying harder". "This is not to say that psychiatric illness is not in itself a real experience, or that it has no biological component, or that the individual suffering it brings is illusory," Thom writes (DSM, 11). I agree with her. This thesis is not meant to denounce the very real suffering that comes from psychiatric illness. But I also agree with Thom's next words: "But what if, instead of asking how mental illness can be contained or eradicated, we asked instead how it can help show us what kind of healing we really need? What if, instead of clinging to the fantasy of mental health in order to deny our suffering, we asked our suffering what it is trying to say?" (DSM, 11). Yes — what if?

Forward

Open in Emergency (OiE) is the 2016 fall/winter special issue of the Asian American Literary Review (AALR), a small, arts non-profit based out of Washington D.C. Described as an arts- and humanities-based intervention into Asian American mental health, the project is comprised of six parts packaged inside a cardboard box labeled "Open in Emergency": 1) an Asian American tarot deck, 2) daughter-to-mother letters, 3) a hacked DSM: Asian American edition, 4) a treated pamphlet on postpartum depression, 5) a foldout testimonial tapestry, and 6) an editor's note also containing contributor notes and biographies. OiE features guest editor, Mimi Khúc, five curators (erin Khuê Ninh, Eliza Noh, Tamara C. Ho, Long Bui, and Audrey Wu Clark), and over 75 other contributors, many of whom are academics, artists, and activists. Three years in the making, OiE was brought to life through a Kickstarter campaign that raised $23,517 of its initial $10,000 goal in two days.[4] OiE is currently sold out, though a reprint, with new materials, is currently slated to come out in August 2019.[5]

The responses to OiE since have been far-reaching, with multiple professors adapting the materials for classroom usage. There is a Facebook teaching group that connects various professors and students seeking to further engage with the materials, and an online teaching platform is currently in the works (Khúc, 2019). OiE has also been included in news coverages that discuss how the Kickstarter campaign raised this money in two days, or how this project uses Tarot and art to raise awareness for Asian American mental health.[6] However, not all the responses to OiE have been positive. In April 2018, Khúc visited Vanderbilt University to deliver a talk entitled, "Hacking Psychiatry: Race, Gender, and Community." In it, Khúc discussed an email that she had received from a professor of psychiatry. The email had expressed concerns over OiE disseminating information that did not have "basis in actual psychiatric / psychological research and science" (Khúc, 2018).

Additionally, as the professor of psychiatry continued, "I don't think I see anyone who seems *formally / directly* involved in mental health care itself: like a *department of psychiatry or psychology* or a licensed professional in that regard…if that's actually the case, it seems like a huge missed opportunity for direct outreach and collaboration with providers who could *actually* bridge the well-known gap and stigma between Asians and mental health care" (Khúc, 2018, emphasis added). As this experience demonstrates, the notion that expertise and 'real' accounts of suffering can only be spoken about using the frameworks of scientific rationality and proof circulate not only widely, but deeply. Projects that seek to contest this framework are subjected to skepticism and the downplaying of its legitimacy, reducing the contributions found in OiE to "just" a collection of stories.

This response to OiE did not come out of nowhere, however. Before proceeding further, it is necessary to contextualize OiE within a larger landscape of psychiatry as a field of knowledge. Much of the "intervention" that OiE is trying to make is already saliently inflected by the histories of the psy-disciplines, of the ways in which expertise has been understood and demarcated, and of how cultural objects – such as the DSM – shape the contours of diagnosis, treatment, and pathology. Alongside the history of the psy-disciplines, OiE is also maneuvering alongside traditions that have aimed to "speak back" to psychiatric expertise. A brief account of this history, which includes an introduction to anti- and critical-psychiatry, as well as Mad liberation movements, is needed.

Historical context

Though madness, broadly construed, has existed throughout history, some have argued that psychiatry did not emerge as an organized field of expertise until institutionalization began, or what Foucault called the

"great confinement" (Foucault, 1988; LeBlanc et al., 2016). Others, like Peter Miller and Nikolas Rose, have cautioned against viewing the rise of psychiatric expertise and institutionalization as coterminous, arguing that the treatment of those seen as mad extend beyond just the walls of the asylum (Bynum, et al., 2010; Miller & Rose, 1986). The dominance of medicalization further encoded madness and insanity into its contemporary form of mental illness (Foucault, 1988; Horwitz, 2002; LeBlanc et al., 2016). Views of mental illness reflected what was perceived as violations in the natural and social order, often being linked to poor moral behavior and living conditions (Grob, 1991; Rimke & Hunt, 2002). In other words, deviant behaviors began to be seen as pathological, and thus mandated systems to classify, diagnose, and contain.

One attempt at a nosology of mental illness was the 1918 *Statistical Manual for the Use of Institutions for the Insane*, which was initially created to meet Census Bureau requirements in the United States (Grob, 1991; Strand, 2011). The need for clearer categories, fueled by post-WWII psychodynamic and psychoanalytic influences and the increased presence of military veterans whose symptoms demanded a clearer classification than the *Statistical Manual* could provide, eventually manifested in the publication of the *Diagnostic and Statistical Manual of Mental Disorders-1* (DSM-I) by the American Psychiatric Association (APA) in 1952 (Grob, 1991). Despite its name, however, the first iteration of the DSM was less diagnostic than it was definitional, due to its then-psychoanalytic influences. When the DSM was revised to the DSM-II in 1968, it featured more diagnostic categories than its predecessor, and with an even greater inflection of its psychoanalytic traditions (Strand, 2011).

However, the DSM and, more broadly, psychiatric expertise were not without criticism. The 1950s and early 1970s in America were especially important to growing pushback against psychiatry, with growing accounts of anti- and critical-psychiatry, and what came to be known later as Mad liberation movements.[7] These challenges to psychiatric expertise were significantly bolstered by a counterculture marked by political critique and challenges to authority, including, but not limited to, the civil rights movement, feminist movements, gay rights movements, and antiwar protests (Coleman, 2008; Tomes, 2006). The radical restructuring of US mental health systems between 1950 and 1970 also involved arguments for deinstitutionalization, new psychotropic drug treatments, and increased legal concepts of patients' rights, which markedly shaped the experiences of those mentally ill in the US. However, much of the dissent during this time came from professionals in the field – psychiatrists, lawyers, and academics – and not from the patients themselves (Tomes, 2006).

Academic literature, in particular, paralleled the political activism that was happening during this time, offering an explosion of works that used "madness" not to signify individual pathology, but to highlight

on sites of injustice, abuse, and coercion (Coleman, 2008). Famous amongst this growing body of literature were academics such as Michel Foucault, Erving Goffman, and Thomas Scheff, in addition to psychiatrists such as Ronald Laing and Thomas Szasz (Crossley, 2006). This growing body of academic work animated what came to be known as anti-psychiatry, which increasingly focused its critiques on psychiatric classification as being methods of coercion. Szasz, for instance, famously stated that most mental illnesses are not illnesses at all, but rather, are names "for problems in living" (Szasz, 1961). Psychiatric classifications, then, were less of an issue of "actual" psychiatric illness and were more reflective of socio-political sites of injustice.

This growing body and influence of anti-psychiatry, combined with the politically-charged milieu, further energized a growing body of psychiatric critique that came from survivors of institutionalization and psychiatric abuse. Known as the Mad liberation movement, this grass-roots movement was, as Nancy Tomes argues, historic insofar as "the claim to have special insight into mental disease by having actually experienced it was a novel assertion. It was on precisely these grounds that ex-patients, as individuals and in groups, began to assert a new entitlement to speak on their own behalf" (Tomes, 2006). In addition to advocating for legal rights over the treatment of their bodies, survivors and advocates aimed to "talk back" to psychiatric regulation of the meaning of mental illness, rationality, and madness, and its significant entanglements with larger issues of social inequity and injustice.

In addition to the epistemic challenges posed against psychiatry in the form of anti-psychiatry literature and Mad liberation movements, psychiatry was also under epistemic crossfire in relation to its diagnostic methods and ways of knowing. The DSM-II was considered too vague for diagnostic reliability and its psychoanalytic influences too weak to shore up scientific, psychiatric expertise (Coleman, 2008; Whooley, 2010). As a result, the DSM-III (1980) eclipsed previous psychanalytic traditions and moved toward a more neurochemically-based understanding of mental illness. The new iteration of the DSM provided its practitioners more standardized criteria for diagnosis, but also included recipe-like descriptions of more than 292 disorders, over 100 more than had previously existed in the DSM-II (Coleman, 2008; Strand, 2011). The DSM-III signified a new era of diagnosing and of scientific expertise that reflected "an amazingly idealized notion of 'theory neutrality'" (Lewis, 2006). Combined with the marketing practices and growing influence from pharmaceutical companies, understandings of mental illness became codified in biomedical models, with the DSM becoming deeply entwined with the professional practice of psychiatry (Coleman, 2006; Whooley, 2010).[8]

Despite the significance that pharmaceutical companies and cultural objects like the DSM hold in the practice of psychiatry, the landscape of how closely psychiatrists adhere to these dominant understandings of

mental illness is varied. For instance, as Owen Whooley has shown, some psychiatrists hold a "sociological ambivalence" toward the DSM that arise through the tensions from professional expectations and individual autonomy in practice. Employing workarounds that undermine the DSM in practice, psychiatrists negotiate diagnostic categories and their engagement with the DSM in their patient settings (Whooley, 2010).

Furthermore, there is a growing move toward critical psychiatry in Britain and elsewhere, which first originated with David Ingleby et al.'s contributions to *Critical Psychiatry: The Politics of Mental Health* (Ingleby, 1981). Critical psychiatry, unlike anti-psychiatry, does not engage in arguments of whether or not psychiatric illnesses are real. Miller and Rose, for instance, have argued that that it would be more effective to critically navigate the social and political functions of psychiatry as a social practice (Miller & Rose, 1986; Thomas & Bracken, 2004). Although in flux about what critical psychiatry involves, main themes involve 1) a critique of pharmaceutical industry's influence within psychiatry, 2) the on-going process of establishing "a medical discourse about mental suffering that is sensitive to the issue of meaning", and 3) ways of promoting partnerships with an emerging user / survivor movement (Thomas & Bracken, 2010). Ultimately, critical psychiatry does not deny the existence of mental suffering and attempts to be reflexive in the histories and epistemologies that have shaped and continue to shape its landscape and practice.

Ultimately, OiE is situated within these histories of psychiatric expertise and how its methods and epistemologies shape the legibility of suffering and deservedness of care. In many ways, OiE's intervention is rooted in the histories of Mad liberation movements, which elevate and take seriously the experiences from patients and those who suffer from psychiatric illness. OiE aligns itself similarly with critical psychiatry in the goals of being critical and reflexive about psychiatry as a social practice. However, OiE also diverts from and expands on the histories that have contributed to a landscape that needs to be intervened in. For one, OiE draws from the arts and humanities that add to ways of making meaning out of what it means to suffer from mental illness that goes beyond just a biomedical understanding. Additionally, unlike some accounts from Mad liberation movements and critical psychiatry, OiE explicitly foregrounds an intersectional approach to understanding the relationships between madness and race, ability, nationality, and gender, among others.[2] Finally, OiE offers up tools beyond a prescriptive diagnostic manual that have been intentionally modified, or "hacked", to better reflect the experiences of what it means to be unwell from those in Asian American communities.

Methodology

This thesis takes influence from the methodologies found in the project to discuss the larger implications that OiE has in unwellness, design, and pedagogy. All of the OiE contributors are writing from what feminist scholars of science have called "situated-knowledge," which is the argument that, contrary to claims about "objectivity," knowledge already is situated within experience, embodiment, and larger, socio-political milieus (Haraway, 2003). Part of the intervention that OiE is making is contesting seemingly "objective" formulations of knowledge regarding psychiatric suffering, reason, and madness. Rather than start with what biomedical expertise has been saying about Asian American mental health, OiE flips the question on its head and instead situates from the actual lived experiences of Asian Americans living through mental unwellness, trauma, and suffering.

I take up this inspiration in my own writing and analysis of this project. For one, I incorporate aspects of autoethnography into areas of this thesis, most notably the beginning "unboxing" and ending "re-boxing" section. Writing as a queer second-generation Asian-American woman, I see parts of my own self and experiences reflected in the voices of these OiE contributors. Oftentimes, during initial readings of OiE, the seeds for further areas of analysis were inflected, quite strongly and affectively, by my own proximity to the project. Rather than pretend I even could separate my own personal experiences from the stakes of writing this thesis — or, even worse, thinking that it would make this thesis somehow less analytical given this proximity — I make efforts to attentively weave in autoethnographic bits where they might fit.

Part of this autoethnographic approach also involves references to personal correspondences with Khúc. For instance, I reference a panel that I was on, as part of her *Hacking Psychiatry* talk that she gave at Vanderbilt University (Khúc, 2018). In addition, I refer to an interview with Khúc for the Contra* podcast, as part of the Critical Design Lab, that was released in January 2019 (Khúc, 2019). And, finally, existing as a teaching assistant and graduate student in the MA program at Vanderbilt University's Center for Medicine, Health, and Society, I pull from interactions and reflections in the engagements that I have had with students.

Finally, I use what Karen Barad terms as *material-discursive practices* to analyze OiE's intervention and how they relate to their design practices. Barad's usage of material-discursive practices come from her critiques of poststructuralist's over-focus on language as definitional and representationalist. Instead, Barad argues for a causal relationship to be drawn between discursive practices and the material *relations* that are thus drawn through these practices. Rather than treat OiE as having "important material factors *in addition to* discursive ones," I foreground my analysis of OiE as a project whose distinctiveness as an intervention relies precisely in how the materiality *interplays* with the discourse and vice versa (Barad, 2003, emphasis added).

As a logistical note about how to navigate citations for this thesis, I will use the following citation practices when referring to specific material from OiE:

DSM: (author, page number); full citation in works cited

Tarot cards: (Tarot, card number)

Daughter-to-mother letters: (Letter, writer)

Postpartum Depression Pamphlet: (contributor when named, PPDP)

Tapestry: (Tapestry, author)

Editor's Note: (Khúc, editor's note)

Stakes

I am a queer, second-generation Chinese-American woman, the only and eldest daughter of Chinese immigrants. I first became attuned to persistent unwellness during my last year as an undergraduate as I skirted the lines between the humanities and the sciences as a philosophy-biology double major who recently made the decision, seven semesters in, to not attend medical school; as I skirted the lines as a "debt-bound daughter" well-aware of the second mortgage her immigrant parents took out to pay for her private school education that was supposed to lead into a medical school acceptance; as I skirted increasingly nagging feelings of guilt and inadequacy and alienation.[10]

At the time, I did not know how to talk through any of this using the discourse available to me, being told growing up that one just "pushes through" and that "mental illness doesn't exist".[11] Because I was also on my parents' insurance plan, and was too scared to seek professional help for fear of later questioning, I could not access institutional accommodations, which require a formal diagnosis. I made it into the university counseling center, twice, only to immediately leave, plagued by guilt because there was a months-long waiting list and I clearly felt as if my unwellness was not bad enough to justify taking someone else's spot.

However, the issues of wellness and unwellness extend far beyond one's individual psyche, despite what a morally-laden health landscape would indicate. One can see not just faint traces of health and wellness, but loud proclamations of it in daily going-abouts. One can see it in workplace wellness programs that offer incentives, often financial in nature, for the completion of certain health goals.[12] One can see it in the ways products and activities, like yoga and meditation, are increasingly sold as being the solution for mental unwellness. One can see techniques that would allow for better optimization (of our selves) that would lead to greater productivity, all in the name of achieving some form of "balance" and "wellness". One can see concepts of "self-care" increasingly circulate on social media and in real life, carrying with it deep-seated

notions of apolitical, American individualism, but not the radical, political undertones that Audre Lorde originally intended it to be.[13]

OiE is described as being an intervention into Asian American mental health. How, and in what ways, is this an intervention? What is OiE intervening *in*? What are the tools that this project gives us, especially in relation to longer histories of psychiatric knowledge and the wellness movement?

In this thesis, I dissect a *logic of unwellness* represented in OiE and argue that this logic does not act as a signifier of individual despair. Rather, it acts to contest the ways in which compulsory wellness depoliticizes and individualizes accounts of being well. These critical, epistemic moves are manifest through OiE's design decisions, namely the act of "hacking" as it relates to whose knowledge, in accounts of unwellness, is seen as valid. Finally, I trace my experiences teaching this in classrooms, where I link up OiE with a tool for a critical pedagogy of care, foregrounding an emphasis on seeing students as having valid accounts of unwellness, inviting and taking seriously these accounts, and prioritizing care as collaborative, interdependent, and joyful.

Unwellness

> "My child," writes Khúc, "the world makes us sick. And then tells us it is our fault. The world tells us what wellness looks like, marks it as normal. Moral" (Khúc, Editor's note).

"Wellness" is a buzzword, saturating many aspects of daily life. Though it is displayed most explicitly, and most absurdly, in the ways the wellness industry sells a type of lifestyle orbiting around vague notions of "health" and "wellness" catered only toward the white and the wealthy — take, for instance, Gwyneth Paltrow's company, Goop, which is now valued at more than $250 million — there are also less explicit ways in which wellness manifests.[1] Vanderbilt's own Health and Wellness site, as a birthday wish, had emailed me, "There is only one of you and taking care of yourself is important. Our gift to you is a reminder that protecting your health at every age is a present you can give yourself." In addition, their own website for Faculty & Staff Health and Wellness is saturated with optimization rhetoric: "Before you begin your amazing journey with Vanderbilt, we want to make sure that you have all you need to maximize your productivity and well-being" (vumc.org). I highlight here, too, the Center for Student Wellbeing's mission statement: "The mission of the Center for Student Wellbeing is to create a culture that supports the personal development and academic success of students using an integrative, holistic framework" (Center for Student Wellbeing).

Oftentimes, definitions of wellness are incredibly vague, looping in other buzzwords like "holistic health," "development," and "potential" as part of its meaning. These previous examples, but a drop in a larger ocean of services, centers, and products promoting some imprecise notion of wellness, dance around the subject. The appeal, as Anna Kirkland emphatically points out, of buzzwords and its corresponding vague definitions, "comes from its ability to float above thorny and contested details and to mean different things to different stakeholders so that it becomes viewed as an uncontroverted good" (Kirkland, 2014b). Despite wellness being seemingly an uncontested good, however, its deployment in campaigns that elevate consumer culture and productivity in reality shores up larger socio-cultural preoccupations with particular notions of health. Furthermore, to hide these prioritized values under an ambiguous umbrella term of wellness "allows for a set of moral assumptions that are allowed to fly stealthily under the radar" (Metzl & Kirkland, 2010). What the history of wellness and the contemporary manifestations of wellness actually reveal is not wellness as an uncontested good, but rather, wellness as individual responsibility.

"My parents just wanted me to be well," writes Shana Bulhan Haydock (Haydock, 45). Though important to caution against the romanticization of mental illness, suffering, and trauma, OiE pushes to ask these

political questions: Why would systems want people to feel and be well? What does wellness confer? And to what ends does wellness help achieve — and for whom? OiE problematizes notions of wellness as they're currently being sold, both economically through the purchase of products and practices aimed at promoting "good wellness", as well as ideologically through the circulation of orientations, beliefs, and affects.

I focus in on wellness and unwellness as central concepts instead of other words, like health, illness, or pathology. This is a deliberate move on my end, and is done so partly through the OiE contributors themselves foregrounding the importance of wellness and unwellness to the project. Just as this project is situated within a larger history of psychiatry, so, too, is it situated within a related history of wellness. Crucially, through this focus, OiE deploys its intervention at several levels, one of which is the targeted critique of seemingly objective, apolitical notions of what constitutes good wellness. The other, through employing a *logic of unwellness*, is a critique of racialized capitalism and the performance of norms that uphold the status quo; this is a larger move that focuses on larger systems of oppression, instead of individual behavior, as barriers to wellness.

Before I indicate how wellness and, importantly, *unwellness* are used in OiE, I want to draw attention to a specific instance in which wellness was used in a *60 Minutes* segment. To do so focuses on a particular moment in which wellness was being evoked, helping to briefly clarify the histories that undergird these contemporary notions of wellness.

Wellness — there's a word you don't hear every day

According to the *Oxford English Dictionary*, although the first invocation of "wellness" occurred back in the 1650s, it first became coded into our "lexicon of health" in the late 1970s (Zimmer, 2010). Between the mid-seventeenth century and the middle of the twentieth century, wellness was taken to mean the opposite of illness (Miller, 2005). A look into 'unwell' and 'unwellness' as terms (via Google Ngram) shows that though 'unwell' was used more than both 'wellness' and 'unwellness' historically since the 1800s, it shows a relatively recent resurgence in the late 20th century.[2] 'Unwellness', interestingly, is not a frequently used term, even in contemporary times — at least not in published books.

Additionally, 'wellness' shows a sharp spike in usage beginning in the 1970s, when the wellness movement began in the US (Miller, 2005). Its frequency is still low, however, compared to other words. 'Holistic' shows a similar trend, one that is higher than wellness but on the rise since the 1970s. The graph for 'psychiatry' is less clean, showing small spikes and dips since the beginning of the 1900s. In general, though, it was on the rise until the mid-1970s, where it then began to decline. And, finally, 'diagnosis' and

'psychology', though occurring at a far greater frequency than both the aforementioned terms, show a small decline and plateau around the early- to mid-1980s.

The specifics of the evolution of terms notwithstanding, it is interesting to note the frequencies of these words, as it can indicate meanings that drive the popularity and politics behind their usage. The subsequent evolution from the 'wellness movement' to today's wellness industry mandates a critical interrogation, as it often paints the concept of 'wellness' as dictated by a) individual choice and b) of being culture-free, apolitical, and innocuous — but only for some.

As an example of the beginnings of wellness culture, the first nine words of a *60 Minutes* video with Dan Rather evokes the following words — "Wellness; there's a word you don't hear every day" — as the pivot point between pre-wellness and post-wellness culture.[3] In the video, Rather focuses on physician John Travis, who studied the works of Halbert L. Dunn, otherwise known as the so-called father of the wellness movement (Blei, 2017). Though Dunn first coined the term 'wellness,' it was Travis who popularized and marketed these ideas of wellness. Specifically, Travis translated Dunn's ideas into an eight-week program, priced at $1500, that included activities like relaxation, improved nutrition and fitness, and self-examination. The goal was to encourage an individual to better understand themselves so that they could then engage in better acts of self-care. As evidenced by interviews and programs like this, Travis increasingly emphasized individuality as part of what it meant to be well (Miller, 2005).

The interesting part of the video comes at the end (3:50), a point rich for further analysis. In it, the video pans to a group of medical practitioners who, for the second year in a row, are meeting with Travis to learn more about how to utilize these "methods of wellness", both for themselves and for their patients. Travis is at the front of the room, explaining some of the criticisms that have been launched at the wellness movement. In response, someone from the audience offers a seemingly indignant retort: "Well I don't like labels, especially with all the latest publicity on cults in the San Francisco area, and I think that wellness, as a concept, doesn't need to have a culture or subculture added to it" (4:12). Afterwards, Travis shares that one physician accused the wellness movement of being a "middle-class cult," which garners two additional responses of interest.

The first, occurring at 4:36, showcases a woman saying, "That's anti the whole concept of wellness, to follow blindly. We are not sheep, and the only thing we're learning here is to take responsibility for ourselves, to question, and to use what fits — for me". The response immediately following that one showcases another woman stating, "And in wellness, you are the leader, you are your own guru, and you're the perfect person who is trying to make your life more better and more full" (4:48).

These three responses lend pause for dissection. I pull out these three quotes to highlight themes within wellness culture, namely those of a) health as individual responsibility ("We are not sheep"), which are common observations surrounding 'healthism' and the neoliberal practice of health; b) wellness culture / industry as, well, *culture*; and c) the defense that wellness is innocuous and apolitical ("I don't like labels") — but only for some.[4]

Since then, the wellness movement has evolved to include multiple forms of wellness models, most of them situated within a business framework of providing wellness camps and wellness items to willing (and able) consumers, and others as situated within workplace wellness programs. The global wellness industry, estimated at occupying a $3.7 trillion market in 2015, comprises categories such as "Beauty and anti-aging ($999 billion)", "Healthy eating, nutrition & weight loss ($648 billion)", and "Wellness tourism ($563 billion)" (Global Wellness Institute). These, according to the Global Wellness Institute, are the top three most profitable areas within the wellness industry.

The wellness movement has even spawned an annual Global Spa & Wellness Summit, "the world's largest conference on the business of wellness," where Travis and Don Ardell, the two attributed as being (additional) "founding fathers of the wellness movement", were the 2014 keynote speakers (Global Wellness Summit). Ardell is on record for describing what he values about wellness: "My own thinking has changed in some significant ways, and for me, R.E.A.L. Wellness — which stands for reason, exuberance, athleticism and liberty — are what's most vitally needed in our world today, and the dimensions too often ignored in most wellness models" (Benzinga, 2014). As Ardell's interview, combined with the brief accounts from Travis, indicate, the type of wellness conscripted by the wellness industry only prioritizes limited notions of what it means to be well, with the "most vitally needed" values reflecting an individual's achievement of wellness through the performance of affirming the status quo.

It is of no coincidence, too, that the wellness movement gained significant traction during the same time period sketched out earlier regarding critiques to psychiatry by Mad liberation movements. A "language of freedom", for instance, is seen as central to both of these movements, though they serve to function in drastically different ways (Coleman, 2008). Many of the political claims launched by survivors involved a right to self-determination in the face of coercive treatments and the scientific legitimacy that uphold diagnostic categories. These claims were political, and much of the activism that was done in the early years of Mad liberation movements involved attention to changing laws that upheld forms of institutionalization and coercion (Morrison, 2005).

A parallel language of freedom is seen reflected in much of the rhetoric behind the wellness industry, notably in self-help literature that is saturated with appeals toward freedom, optimization and "knowing" of the self, and liberty. Inflected by popular and positive psychology, which carries the historical appeals toward mental hygiene, self-help literature marshals in the valuation of affective conditions like happiness and positive thinking alongside appeals toward maintenance of the self as the only avenue in which to achieve health (or, read in a different way, wellness) (Rimke, 2000; Woodstock, 2005).[4] Coleman argues convincingly that rhetorics of freedom and liberty work to both expand *and* limit radical politics: "The sharp edge of many radical claims, often voiced in a lexicon of freedom and liberty, was blunted by a broader set of economic and cultural shifts that entrenched a new commonsense language of freedom centered on the ideas of lifestyle choice and free market principles" (Coleman, 2008). Ultimately, the significance of seemingly apolitical rhetoric within the wellness industry, alongside accounts of wellness by the psy-disciplines, cannot be ignored, and has noteworthy stakes in critical accounts of what it means to be well or unwell.

Unwellness, conduit and catalyst

Deeper historical accounts of wellness, its relationship to the histories of the psy-disciplines, and its stakes in contemporary, twenty-first consumer culture need to be further attended to. Dunn, in his original 1959 paper on wellness, argued for the necessity of a new "health axis" that moved beyond health's framework of either illness or the absence of such and to something called "high-level wellness". This high-level wellness, as Dunn argued, was defined as "an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable, within the environment where he is functioning" (Dunn, 1959). Highlighting the notions of wellness as *individual* responsibility, as something achieved of in the name of optimization and productivity is not new within the realm of critical health studies. As Kirkland has stated in her critique, "Wellness promotes a conservative, individualistic health ideology, thereby undercutting communal, structural, redistributive, and sympathetic approaches to health" (Kirkland, 2014a). Emphatic focus on wellness and individual responsibility — the ability to continuously strive for wellness as an ideal — prioritizes certain actions over others in the name of good wellness, shoring up the idea that only some are moral enough to achieve this ideal.

The OiE collaborators understand how wellness, as this type of bounded, limiting sphere, is much more about excluding people than it is about actually restructuring the affective, scientific, relational, and socio-political landscape to prioritize what good health and wellness might actually mean and look like. These collaborators' ideas of what might help and what it might look like are far-ranging: Shomura's *Public Feelings*

Project, taking inspiration from Ann Cvetkovitch's *Depression: A Public Feeling*, circuits through what he calls the "micropolitics of mental health," foregrounding the minutia of daily life and its experiences (Shomura, 15); Shana Bulhan Haydock's adamant push for the importance of critical psychology (and psychiatry) to not just broaden norms, but to *challenge* these norms and recognize the power in terms such as 'neurodivergent', 'neurotypical', and 'mad pride' (Haydock, 53); Eliza Noh's argument for expanding the methodologies in suicide research ("Is it that my methodology is unclear or that it is not legible within a disciplinary language?") (Noh, 75); and Johanna Hedva's "Sick Woman Theory", in which they contend "that the body and mind are sensitive and reactive to regimes of oppression" (Hedva, 149) are just a few examples pulled from the hacked DSM that showcase resistance to *compulsory wellness*. I derive compulsory wellness from similar deployments of compulsory heterosexuality that describe the pressures to conform to the norms of heterosexism.[5] In comparable ways, items like self-help books, rhetorics of self-optimization, and the marketing of products that aim to literally sell an idea of wellness, divorced from serious considerations of structural and political institutions that significantly shape differential levels of risk and illegibility, serve to reify the drive toward this *logic of wellness*.

This resistance to compulsory wellness is animated by what I call a logic of unwellness. Rather than do away with wellness as a whole, which is dangerous because it then sets up the denial of real psychiatric suffering, I employ *logic* in a similar way that Eli Clare has utilized a 'logic of cure' to describe the ideology of cure that's bolstered through the medical-industrial complex and how Annemarie Mol has deployed a 'logic of care' to describe the everyday experiences of those living with disease (Clare, 2017; Mol, 2008). The logic of wellness here reflects adherence to a seemingly apolitical culture of optimization, consumerism, and individualism. However, this current form of logic, or set of ideas underlying its arrangement, can also hold the potential for restructuring.

To be *un*well, then, within the confines of this logic of wellness, is to mean that one is amoral, marked as ill, pathological, not normal. However, OiE offers up a different way of understanding wellness beyond just descriptive means and toward ways more qualitative, especially in relation to systems of oppression like racialized capitalism. As Khúc prompted, wellness can also signify how *well* one "can perform racialized capitalist productivity or gendered constructions of the self-made / martyring / sacrificing woman-mother" (Khúc, editor's note) A corresponding logic of unwellness, then, is used as a litmus test for factors that shape differential unwellness beyond just the individual psyche or the individual will. In this way, the logic of unwellness can be used as both a conduit and a catalyst for calling attention not to the seemingly existent moral implications found in individual suffering, but toward sites of injustice.

Design

> "Note: We hacked this book, tore out all the pages and replaced them. Thanks, the Editors, AALR" (DSM, 1).

This thesis situates OiE as a project that aims to speak back to codified, dominant, and seemingly uncontested ways of mental health expertise. Through a focus on the hacked DSM in particular, I analyze the design decisions that went into this project and how they are integral to OiE as a political and epistemic intervention.

Hacking

One of the key components of OiE is the hacked DSM. Hacking, here, is used as a metaphor and discursively flags to the user that this DSM is different than the original DSM. What about hacking, its origins, and its history, might make this decision not only appropriate within the context of the OiE project, but also necessary?

Hacking has a long history and relationship with technology and information, most notably with computer programming and engineering. Though fueled significantly by the onset of computer technology in the 1970s, hacker culture also manifested itself in the 1920s with radio and the 1950s with railroad (Galloway et al., 2004). Hacker communities have been well studied, and scholars have looked at some of these communal principles that guide a type of "hacker ethics."[1]

As one example shows, Merriam-Webster provides contradictory definitions for a hacker: one who is a) a person who is inexperienced or unskilled at a particular activity or one who is b) an expert at programming and solving problems with a computer. Despite the inconsistent definitions above, both of these descriptions reveal relationships to expertise as operative within hacking. In addition to the Merriam-Webster definition, I locate two additional ones, rooted within their engineering / computer home base, to focus on.

The first involves "the ability to question the trust assumptions in the design and implementation of computer systems rather than any negative use of such skills" (Bratus et al., 2010). Rather than assume systems are designed objectively, this recognition foregrounds the idea that the design decisions that shape design are already inflected by socio-cultural traditions. The second definition is more oriented toward possible types of ethos guiding hacker communities: "Hacker cultures, then and now, generally embody some combination of the following ethics: ensuring access to technology and knowledge about it; putting power in the hands of

users; decentralizing control; protecting privacy; exceeding limitations; creating beauty; and doing no harm to people" (Galloway et al, 2004). Through addressing these examples, I pull out some general trends that are applicable to the type of hacking found in OiE.

For one, the "ability to question the trust assumptions in the design" is crucial to understanding what, collectively, the objects of OiE are doing. The design decisions that resulted in the hacked DSM as opposed to compiling the contributions in a traditional journal were intentional. I argue that these design decisions immediately challenge built-in assumptions of mental health by attaching to it salient objects for contestation. Given the history of the DSM in relation to the psy-disciplines, this decision is especially provocative. Hacking, then, isn't necessarily a brand new object, but rather, it attaches itself to and "challenges assumptions" through the modification of existing objects.

Though recognizing that there are hackers who work alone within the engineering, I highlight on the third definition of hacking as culture to draw attention to the political nature that some variants of hacking can take on. This definition is especially important as it situates forms of access as key motivators behind hacking. Most notably, some hackers and hacking communities seek to make information open-source instead of policed by ability to pay, or hack existing designs and objects to make them more usable for the actual users who interact with them. "Hackability implies more than simple customization or adaptation — it calls for redefinition," write Galloway et al. for a panel on designing for hackability. It is this last part of "hackability" that I center on in relationship to AALR's design process and OiE as a final form.

The discourse of "hacking the DSM" is such a crucial part of OiE that I asked Khúc about her process of hacking during our interview. AALR's approach to literary and creative work has always been, according to Khúc, to "do things that we think people need, and not what they want. Because what people want is often just what they already know. And so, just trying to figure out what people need requires stepping outside of what people know and what they'll expect. So AALR has been very playful in that way, trying to play with forms in order to do a little bait and switch. I consider hacking a little bit of bait and switch, right? We're going to give you a DSM, but it's not the DSM you thought you knew" (Khúc, 2019). This "bait-and-switch" is particularly jarring and critical to the project's intervention for two immediate reasons.

The first centers around notions of expertise, as the Marriam-Webster definitions showed. Existing within a historical tradition of "talking-back" to psychiatric expertise, the contributions found within this hacked DSM represent alternative, but no less valid, forms of expertise and ways of engaging in not just mental illness, but also trauma, suffering, activism, and ways of knowing. The original DSM has consistently been used as a tool that not only diagnoses, but also polices, experiences that do or do not count as mental

illness; in doing so, it falls into the pitfall of standardizing what "normality" looks like, pathologizing behavior that falls out of these definitions.[2]

The second highlights on *material play* as something that is integral to this type of hacking. Within the hacked DSM, there are two opportunities for users to engage with this type of material-discursive intervention: Chad Shomura's *Corner of Heart-to-Hearts* (Shomura, 17-20) and Genevieve Erin O'Brien's *Selfcare* cards (O'Brien, 127-136). Shomura's cards are simple: white, bolded words printed on black background. These cards, which can be ripped out of the DSM and cut to represent playing cards, encourages a radical sharing of otherwise private, intimate feelings. O'Brien's cards act in a similar way in that they can also be ripped out and cut into a deck. One side of the card showcases photos from O'Brien's own Instagram, such as succulents and Kombucha. On the back reflect O'Brien's take on what self-care can look like beyond the apolitical types of self-care circulated within the wellness industry.

However, the playfulness of the project does not stop and end with just the DSM — every single aspect of the project involves some form of tactile engagement, from opening the letters to thumbing through the Tarot deck to unfolding the testimonial tapestry. In addition to the pages that can be physically ripped out, the DSM also involves annotations throughout, with the highlighted words and comments acting as additional layers of interpretation and engagement. "It creates a different experience when you have to take it out of an envelope, open it up," Khúc states. "There's a kind of intimacy that happens when you feel like you're actually reading somebody's intimate writing that they had sent" (Khúc, 2019). This kind of intimacy can paradoxically be as inviting as it is jarring; inviting in the ways in which one might see similar experiences reflected upon the page, yet jarring if some of the accounts deviate from what one might have originally thought or felt.

Circuits of love

Jentery Sayers opens up *Making Things and Drawing Boundaries: Experiments in the Digital Humanities* with this phrase from artist Laurie Anderson: "Well, I don't know all the circuitry, but I can do first aid" (Sayers 2018). Sayers uses the case of Anderson, who has years of experience in media systems and technology, to exemplify negotiation instead of epistemic certainty. Anderson, despite all of her knowledge, never claims to understand circuitry "all the way down" (Sayers, 2018). I use this type of *circuitry* as a useful metaphor to extend into OiE and its interface with design, expertise, and relationality.

The epistemic intervention at play in OiE bears similarity to what Thomas Gieryn terms "Boundary work," in which he uses it to demarcate work that is considered scientific from non-scientific (Gieryn, 1983). "Boundary work" here describes practices of ideological demarcation by scientists as it relates to claims to

authority. Though contingent upon historical priorities, boundaries are drawn according to what characteristics (such as empiricism) might best elevate these types of expertise. Taken into context of OiE's intervention, this type of boundary work is reflected within the histories of psychiatry as it negotiated and then coded meanings of mental illness and suffering. As an intervention, OiE disrupts and blurs these epistemic boundaries by contesting who is seen as having legitimate access to speaking about mental health, unwellness, and psychiatric suffering.

In my interview, I had remarked to Khúc that it is impressive that so many of OiE's contributors come from such a diverse array of backgrounds. How, I had asked, did one go about finding all of these contributors?

> "Well who's doing mental health work? … When you first ask that question, most people look to psychology and psychiatry. And we're like we're not going to look there because we actually think that there are artists, and writers, and Humanities scholars *who are doing the work who may not call it that*. So can we be more expansive? Thinking about what mental health is, and what the work looks like. The question [then] becomes more about who's doing work on suffering, and pain, and meaning-making, and survival, and trauma…Then there's tons of people doing that work, and doing it in really amazing ways. So, we saw our job as providing this vision, and this structure, and then just pulling in amazing people doing amazing things. Once you pull them in, and you kind of ask them to do their thing, then I don't have to be the expert on everything. *And they don't have to be the expert on everything, either*" (Khúc, 2019, emphasis added).

I highlight the above interview segment to allow me to circumvent to the very beginning, where I included Merriam-Webster's contradictory definitions of hacking, as someone who is either inexperienced / unskilled or someone who is an expert. Though the OiE collaborators are not, by biomedical standards, considered "experts," it is precisely their treatment of mental health as something incapable of being bounded that leads to its efficacy.

"When you hack, you're directly engaging the thing that you're trying to intervene in, and it grounds it in a certain way. And it makes that alternative speak directly to what it's pushing against, and what it's opening up," states Khúc (Khúc, 2019). Khúc and the other collaborators' treatment of Asian American mental health is similar to the ways that Anderson treats her work with technology. "First aid" as a heuristic doesn't seem to quite fit with what OiE is doing, which implies that this type of work is only suited for minor injuries, which is a gross underestimation to the gravity of which this project is embroiled in. Nevertheless, the fact

that OiE does not purport to be the *sole* voice speaking about mental health is the very core of what makes it a resonant and effective project. These accounts *are* expertise, but a kind of expertise that is porous and does not claim to know "all the way down".

Additionally, this type of flexibility, porosity, and openness reflects Carl DiSalvo's methodology of design, which is not one to be limited to professional design, but, rather, as extensions "across disciplinary boundaries to include a range of practices concerned with the construction of our visual and material environments" (DiSalvo, 2012). Furthermore, by straddling the boundaries of what "counts" as mental health work, and through *re*shaping both conceptualizations and experiences of unwellness and its objects, OiE is acutely adversarial in challenging long histories and conceptualizations of mental unwellness.

OiE's deployment of these intentional design decisions broadens the critique against long histories of psychiatric expertise as sole expertise. Beyond just an epistemic critique of Western, positivistic methods, however, OiE also implicates the differential stakes that come from participating in an ableist, heteronormative, racialized capitalist system. To recognize the ways in which these entwined systems of oppression markedly shape legibility of suffering is a recognition of not just the kinds of power dynamics, but also of "the circuits of love and pain" imbued in these contributors' works and experiences (Khúc, 2019). OiE encourages an recognition that foregrounds fluidity and negotiation, rather than utmost certainty. This recognition is ultimately important for those making meaning of unwellness, as well as for those in power, such as psychiatrists, in their engagements with those who are unwell.

Pedagogy

> "Over the last 6 years, I have worked to develop a pedagogy of unwellness: a pedagogy that starts with the radical recognition that we are all differentially unwell — including my students, including me. I not only teach about unwellness — mental health, race+racism, structural violence — I teach with the assumption that we are all shaped by structural unwellness and that the purpose of the classroom space is to learn the contours of that unwellness and discover how to live through it" (Khúc website).

Have institutional actors on campus, such as professors and administrators, ever asked students if they feel well on campus, and why might it matter if they do or do not? Just as ideologies of wellness circulate across social media and within a specific socio-political milieu, so, too, do issues of wellness and unwellness circulate inside classroom spaces, within student emails and assignments, and around university campuses. OiE is a project that is as experimental as it is influential, urgently pushing for accounts of unwellness to be taken seriously by those in power, which involves doctors and medical professions just as they involve professors and university administrators. In this section, I analyze how OiE gets taken up as a pedagogical tool, and how accounts from students regarding their own wellness and unwellness reflect how university structures and norms might contribute to such.

This urgent call to ethico-political charges of unwellness found within student-professor interactions and how university mental health systems are structured is saliently inflected by my own proximity to the issue. For one, I exist in a liminal space as both a graduate student but also as a teaching assistant. I have witnessed, through assignments and in the micropolitics of emails written about an absence or an extension, of the ways in which students might reveal their own relationship to diagnostic categories or unwellness more broadly. As examples, I have had students share how adjustment to medications, the grief following a friend's suicide, and feelings of anxiety, burnout, and exhaustion have interfered with their ability to come to class or turn assignments in on time. In other cases, when I have directly asked students how they see diagnostic categories play out on a university setting, some had remarked that official accommodations are difficult to enforce and that professor responses to student accounts of unwellness are varied, sometimes even by discipline.

Why, I wonder to this day, was my friend, who had stayed up late one night to help a suicidal friend (and thus missed class the next day), met with two drastically different responses from her professors? The

first had remarked to her, "Friends are important, but you made a commitment to be in this class. I understand that your suicidal friend made an attempt on her life, but on Tuesdays and Thursdays from 10:00 - 11:15, this class needs to be your number one priority…I thought you were going to be the best student in the class. That's not what I've been getting from you. This is the second class that you have missed. You're welcome to withdraw" (personal correspondence, 2017). The second had told her that she was only going to be a student in that class for a few more weeks, but that she had to be human for the rest of her life, and was glad that she was there for her friend. This small anecdote is an example of navigating academic markers of "success" — completing assignments, engaging in participation, and regular and consistent attendance — alongside issues of unwellness.[1]

Before delving further into situating care and unwellness into the classroom space, I want to make especially clear that the importance of care in the classroom does not mean professors should be substitute mental health professionals. Universities, as has become an increasing trend, that launch mental health campaigns often have some variant on professor "open doors" hours for talking about these issues.[2] These trends, which shift the emotional labor onto its professors and staff to care for students, is an abdication of a university's responsibility for addressing underlying structural issues that contribute to unwellness. The issue of care work can be especially hard for professors with large class sizes or who themselves work under precariously-charged conditions that demand significant time and energy. Additionally, *who* is doing this care work (and *for whom*) — questions that are absolutely inseparable from issues of gender, race, and class — also needs to be continuously and emphatically inserted into this conversation.

However, the answers also cannot be that care is outside one's ability to give just because one is not "professionally trained." As OiE has shown, biomedicine and professional expertise do not have sole patent over what care can look like. At the end of the Vanderbilt panel last year, a student asked the question of how they can care for their struggling friend when they are not a "professional." This section on pedagogy is an attempt to navigate these liminal spaces between the poles of a) abdication of care by those who are not "professionally trained" through referrals and b) what care work, through empathy and belief in students, can look like. I use Khúc's "pedagogy of unwellness" as a useful guide for how OiE can be taught in the classroom. Along the way, I incorporate some of my own pedagogical components that I've used to teach OiE in Aimi Hamraie's *Theories of the Body* class. I ask, why, as Khúc wrote, this would be considered a "radical recognition" for pedagogy? What is the place of unwellness and care inside the classroom? And, finally, how can OiE be used for teaching with unwellness in mind?

A "radical recognition"

In June 2017, *The Chronicle of Higher Education* published an article titled, "To My Student, on the Death of Her Grandmother(s)." "Please accept my sympathy on the death of your grandmother(s)," writes Shannon Reed, laying out terms that the student needs to complete before Reed accepts a late assignment, which includes bringing a copy of the obituary, following a version of Victorian mourning, and being subjected to the professor checking in to see if the student is displaying forms of "real grief" (Reed, 2017).

The article was meant to be playful, a satire on students "killing" grandparents as a way to gain extensions during finals season. However, what the article fails to acknowledge is that by assuming students lie about dead grandmothers because they might be irresponsible or lazy, it sets up students as adversaries to be mocked on public forums such as *The Chronicle* or Twitter.[3] It may very well be true that some students do lie about dead grandmothers during finals season to get extensions because they chose other things over studying all semester. It may very well be true that some students resort to gaming the system through their own poor planning and time-management skills. However, if that is true, it is also very well true that some students do, indeed, have grandparents pass away during finals season, and it could very well be true that students do, in fact, lie about dead grandmothers as a stand-in for other reasons.

"We accept that grandmothers die (at least, we did until the Chronicle updated us on that!). So dead grandmothers may actually be stand-ins for things we won't accept, can't know about, shouldn't know about, or won't otherwise believe," writes the anonymous poster, Acclimatrix, on the blog, *Tenure She Wrote*. Acclimatrix argues that articles like the *Chronicle* construct a binary between students and teachers and begins from the point that believing students who would dare ask for extensions — especially during precariously-charged times like finals season — are lying and are out to game the system. This binary thus negates the idea that students would encounter situations that would affect their ability to complete assignments on time, or if they do, that it would be something that would not take precedence over academic demands. Consequentially, this kind of thinking ignores the ways in which both students and faculty are made differentially unwell through traditional academic structures and standards of rigor.

The ways in which discourses of unwellness are taken up and responded to are indicative of being "against students." Sara Ahmed writes provocatively of how recent discourses on "problematic students" are only problematic because they threaten the status quo of the academy. Specifically, she cites increasing instances of students speaking up against sexual harassment / assault in higher education and critiques against the colonizing nature of knowledge production as examples that are seen as a "threat" (Ahmed, 2015). Though Ahmed is writing within the framework of institutions not taking seriously instances of student sexual harassment / assault, I argue that this heuristic can also be salient for issues of unwellness in the classroom.

As Margaret Price has demonstrated in significant detail, there are assumptions (of both students and professors) regarding the type of wellness — compulsory wellness — that circulate within the academy (Price, 2011). These notions of compulsory wellness often are traced to a student's ability to "work productively," as the WHO definition of mental health indicates, which shows up through taking multiple courses and participating in numerous extracurricular activities (Thom, 6). This idea of "functioning" (well), as Thom points out, aligns itself with this performance of high productivity and participation on a university setting. And on a campus that supposedly has "the happiest students," this performance of wellness also involves a display of happiness and independence, whereby, and despite campus campaigns, one's mental unwellness is pressured to remain masked.[4]

When academia privileges certain students who reflect the markers of compulsory wellness, it creates an academic landscape in which care, interdependence, and recognition of factors that make students and faculty differentially unwell seem wildly out of place. As one student remarked in Hamraie's class, they felt as if their relationship with professors was "transactional," reflecting a perceived student-professor relationship as only marked by the exchange of assignments for grades. A pedagogy of unwellness, on the other hand, allows both professors and students to move beyond this framework by recognizing the proximity pain and experience have in teaching.

"Teaching is a recognition of pain," Peggy Lee argues, which manifests in the classroom through *what* is being taught alongside *who* is being taught. A pedagogy of unwellness foregrounds the idea that the students populating the classroom are not a homogenized group and carry with them legitimate experiences that significantly inflect and shape understandings of and contributions to class materials and life in a neoliberal university. Furthermore, it elevates accountability from both professors and students beyond just the completion and grading of assignments. To teach with unwellness in mind is to recognize the political significance of what is prioritized in the classroom and the potential effects it may have on students, both affectively but also intellectually. In turn, students are held accountable in their engagements with each other and of the array of ways in which their own experiences inflect what they need and how they feel.

OiE and teaching with unwellness in mind

My opportunity to teach OiE in the classroom was broken down into two days; the first was focused on the DSM and pamphlet, and the second was focused on the letters and tarot cards. My main attention in using OiE as a pedagogical tool of unwellness will focus predominantly on the former. There were about 25 students in the classroom, ranging in grade levels from sophomores to seniors. Furthermore, the students

reflected a diversity of majors, but, notably, many of them were Medicine, Health, and Society (MHS) majors. Some of these students also openly shared that they were on the pre-medical track, as indicated by how many of them were also taking pre-requisite classes like biology or organic chemistry. As the 'unwellness' section earlier indicated, wellness narratives that carry apoliticized and individualized notions of self-optimization for productivity circulate widely. This takes on particular salience on a college campuses where issues of student mental health and wellness in general mandate a critical examination. To that end, this day of teaching foregrounded accounts of unwellness from students, located both experientially and spatially.

My first question to the class was to poll these student ideas of what constituted unwellness, wellness, and care. These answers can be found in Figure 1. Similar to the values prioritized by the wellness movement, the student answers to "what is wellness?" orbited around ideas such as productivity, functionality, and an absence of co-dependency ("Do not need to rely on others"). One student alluded to "norms" as being tied in with wellness. Interestingly enough, answers to "what is unwellness?" also called attention more individually experienced phenomenon – "lack of control," feeling "isolated/lonely," and experiencing too much social media surveillance – as opposed to larger structures that might make one feel unwell. Finally, though there was one student who described care as being defined as "community," many other students detailed a more individualized definition of care centered on "self-reflection," being "intentionally unproductive," and dealing with stressors (what kinds of stressors were not detailed). Like circulated wellness narratives and buzzwords in consumer culture, student answers to what "feeling good about self" and having "good mental health" reflect a mark of vagueness and individual subjectivity that is hard to pin down in specifics.

One of the significant parts of class also involved a digital map of places where students feel unwell or where they feel cared for. "What places on campus do you feel well or unwell, cared for or not cared for?" I asked. I utilized Google My Maps, which allowed the students to anonymously drop pins on a map of Vanderbilt and its surrounding areas. From there, the pins were color-coded based on whether students felt unwell / well and cared-for or not. A screenshot of the pins (along with the link to the map itself) can be found in Figure 2. The congregated density of pins around some areas more than others (such as Stevenson, detailed below) reflect a collective experience of unwellness. Additionally, the *lack* of pins around places that seem to be, on first pass-through, sites of care reflect how students may feel either alienated from or ambivalent about these campus resources. And, finally, because students were also encouraged to add anonymous comments corresponding to these places, I was able to pull out how university decisions about financial aid, food, and construction also came to shape student experiences of unwellness on campus.

Stevenson — More so than any other location on campus, Stevenson was the site of unwellness and the absence of care. Built in Brutalist style architecture, Stevenson is home to STEM classes and a science and engineering library. Most of the student answers talked about how stressful the STEM classes are and how "behind others" some feel when studying at the library. "It's where fun goes to die," writes one student.

These student responses and the corresponding quantity of which students expressed similar sentiments toward Stevenson reflect a larger relationship between of STEM education and the centrality of it to the university. Increasingly, universities are highlighting how STEM education can translate into job marketability, which runs counter to the narrative that STEM provides something (like profitability) that a humanities training might not. This is increasingly paramount within the neoliberal university, which increasingly focus on modes of production that prioritize what is most profitable to the university. These pressures and changing landscapes reflect the funneling of students into these types of majors and pre-professional tracks, where class sizes might be too large for professors to engage with students on a more personal level.

Additionally, the type of pedagogy found within these spaces also has something to indicate about shaping a student's unwellness. Lee argues that it is "vital to cultivate a learning and doing of knowledge that does not fall into the fiction that somehow proximity to pain and its articulations are forms of intellectual retrenchment or loss in academic 'rigor'" (Lee, 97). STEM fields often prioritize "objective" ways of teaching about science that do not provide room for subjectivity, and often at an unforgiving and fast pace to keep up with all the material, shoring up these aforementioned values of so-called academic rigor.

Center for Student Wellbeing — The Student Wellness Center was established at Vanderbilt's campus in August 2016.[5] Contrary to the collective density reflected in Stevenson as a site of unwellness, there was no density associated with the Center. The opening of the Center was spurred from some student activists, but the lack of students actually seeing it as a resource is curious. For instance, it is unclear whether this is due to a lack of knowledge about its existence, whether students are just "too busy" to take care of themselves, or whether they feel ambivalent about this campus resource actually providing them the care that they need. If I had to hazard a guess, however, based upon my own experiences and the brief conversations that I've had with students, I would argue that it is a combination of the first and the last point. Biologizing language surrounding mental illness holds water given the histories of the psy-disciplines and scientific legibility. This might have to do with why more students had accounts (good or bad) to share about the University Counseling Center, which provides counseling and psychiatric referrals. Additionally, I argue that university decisions to provide greater mental health resources often times do not actually include, take

seriously, and elevate what students might actually need, possibly contributing to feelings of ambivalence and alienation toward centers like these.

Abstracted impacts — The design of my questions and of Google My Maps emphasized physical places of un/wellness. For some of the students, it seemed like their answers really were localized to a specific place (Stevenson for stress, their dorm room for wellness as examples). However, I highlight on three significant factors on student wellness that can be abstracted from their locations on Google My Maps. One student had put Rand as a place where they did not feel cared for, highlighting the food choices. This student's dissatisfaction may or may not have to do with the controversy in Vanderbilt Dining that happened at the beginning of the 2018 academic year.[6] Another student highlighted the financial aid office as being a site where they did not feel cared for, and another student, in their comments about the administration building, wrote, "The people who work in this building only care for the future reputation of the school and not the mental state of its current students…Construction that wakes students up early in the morning? Sure!".[7]

I argue that "to teach with unwellness in mind" is to recognize the place that affect, personal history, care, and vulnerability have in classrooms and in the academy. Instead of taking vulnerability — these whispers and proclamations of things that make students and professors feel unwell — as weakness or excuse, too frail to stand up to the demands of so-called academic rigor, students and professors can, instead, take them as provocations that indicate toward larger sites of injustice and politics. Furthermore, a pedagogy of unwellness foregrounds the important recognition that students also have valid accounts of their lives and the forces that shape their unwellness on a college campus. Like Lee demonstrated in her *invitation* to students strategizing collectively ways of communicating and caring, recognizing student experience is to ask, elevate, and take seriously what students have to say.

Pedagogy and politics of care in the classroom

I end my last section of this thesis on the possibilities of a politics of care in the classroom. "The most anti-capitalist protest is to care for another and to care for yourself," writes Hedva. "To take on the historically feminized and therefore invisible practice of nursing, nurturing, caring. To take seriously each other's vulnerability and fragility and precarity, and to support it, honor it, empower it. To protect each other, to enact and practice community. A radical kinship, an interdependent sociality, a politics of care" (Hedva, 150). A politics of care is indeed necessary, but I would caution against taking care as a homogenized and *de facto* good. Michelle Murphy, in the special issue of care in the *Social Studies of Science*, argues against always equating care with positive feelings given its violent histories in shaping North American feminist health movements

and histories of racism, colonialism, and class privilege (Murphy, 2015). As this argument helps to demonstrate, structures, practices, and discourses *offered up as care* can be violent; sometimes the rhetorical move of "I/we care for you" is paternalistic and actually silences the voices of those purported to be cared for.

Taking a politics of care as a critical project is to also recognize that, just as it does not always correlate with positive feelings and affect, care is not always easy. As disability justice activist and writer, Leah Lakshmi Piepzna-Samarasinha argues, care is work. Care is labor. Care can be exhausting. "I had no idea that any of this — that all of this labor really was work, that I was tired from working hard, not from being lazy; that I might need some quiet and space; that being hyper-accessible was killing me," writes Piepzna-Samarasinha on the importance of boundary-setting when doing care work (Piepzna-Samarasinha, 2018). Piepzna-Samarasinha writes within the context of disability justice that moves beyond a disability rights framework and toward one that centers on disabled, queers of color, calling attention to the ways in which multiple forms of oppression intersect (Lamm, 2015; Piepzna-Samarasinha, 2018). At its heart, disability justice is an anti-capitalist critique, grounded in collective interdependence over individualism, that adamantly argues against measuring one's worth by how productive one is.

Two of the student answers to the "what is wellness" question involved "self-care" and being "independent, functional" (Fig. 1). A politics of care, as reflected through the lenses of OiE as a project and intervention, encourages the opposite of independence. I imagine — and actively hope for — ways of grappling with care within the classroom, of taking seriously student accounts of unwellness, of crafting gentle ways of teaching when energy is lacking and landscapes are precarious, of ways that shift notions of care, as Piepzna-Samarasinha encourages, toward "a collective responsibility that's maybe even deeply *joyful*" (Piepzna-Samarasinha, 2018, emphasis added). Students, professors, colleagues, friends, and service workers, as Lee encourages, can be involved in this collective responsibility, or what Piepzna-Samarasinha also describes as "care webs" (Lee, 97; Piepzna-Samarasinha, 2018). In this way, normalized ways of upholding ideals of individualism can, instead, be transformed by a recognition that to care and to be well involves a joyful valuation of interdependence.

Conclusion

Re-boxing

All of the contents are now scattered across the table; the cardboard box lies next to me, strangely hollow. I note the emptiness in my mind as I move to gently pick up the hacked DSM. There is a long, vertical crease in the cover, perfectly aligned with the left side of the gold border. Opening the cover carries with it little resistance like the very first time I opened it. In the process of flipping through the pages, themselves decked out with post-its of all different sizes and colors, I land on James Kyung-jin Lee's *Liturgy*. There is a natural crease in it, as if I've turned to this passage a million times before.

"Pay attention to these details because they might hold the secret to your life, or what is possible in your life, even or especially when those details bring you to moments of pain, grief, suffering," he implores (Lee, 79). These details, these ancillary details that otherwise would be brushed aside as fleeting or as minutia, matter. Look, Lee writes, "for the liminality of these feelings when institutions have failed people, failed you" (Lee, 79). These fleeting moments, these small details, quickly flash across my brain before they disappear: when I had to walk without my best friend on graduation day because his depression prevented him from fulfilling strict attendance requirements for a core class; when my own energy levels had run terribly low from my anxiety convincing myself that there was everything to worry about and my friend called me saying he was having intense suicidal thoughts and I told him that though I could not muster up the energy to talk, I would stay on the line with him if that was okay and he later wrote me a poem entitled 'Even Silence Can Save a Life'; when I scroll through the now sensationalized Facebook page, Subtle Asian Traits, looking at memes posted by other Asian-American kids joking about how they've failed to achieve family expectations and the ways I wryly laugh as my heart whispers, *same here*.

But, I would add, the moments of *joy* matter, as well, even if they're so quick footed that they evade capture: the smell of my favorite fall-inspired tea that helps calm me when I feel like the world is crumbling around me; the subtle *click* of my film camera when it helps get me out of bed on those days that just feel impossible; the way that my heart whispered, that first time I taught OiE, *can we do this again? Can we think of more accountable ways, better ways, to care for and about students in the academy? Can we provide more opportunities that allow students to talk about how they feel unwell, and can we collectively dream of ways to care for each other?*

I slowly lay the DSM inside the box, knowing it most certainly won't be the last time that I rebox it. I reach for the tapestry next, lay it on top. I reach for the envelope of letters, next; the flap is nearly falling off because I've creased and re-creased it over and over again. I hope that I write more letters to those around me. Maybe even one day I'll send my parents the letter I've been crafting in my mind the past two years. The

pamphlet goes next, and then the Editor's Note. I want to do one last Tarot reading. "How do I continuously practice care and interdependence as I move forward?"

I flip the top card: Death. "As the first numbered card rather than the last in the major arcana, death is a reminder that the struggle for dignity and simply existing is real and ongoing. Its primary place in our social plane sustains the will to fight against forced labor, state brutality, and even the invisibility associated with social death. The card encourages those in pain to open up their minds to what they can do to change the horizon of being" (Tarot, 1). I am initially unnerved by such a seemingly macabre reading, but remember that Death, in this case, can also signify transition: "It portends the end of a difficult journey, the rising of oppressed people from the ashes of destruction to lay claim to a new day" (Tarot, 1). In many ways, I needed the materials found in OiE as a way to make sense of my own East Asian American identity, as well as in my relationship to the inflections of unwellness, wellness, and care found in my own being-in-the-world. I end this Tarot reading on a hopeful, determined note to further grapple with how the norms and systems of oppression that exist shape the legibility of suffering – and of ways to transform them.

Open in Emergency. I know that next time, both during an emergency and not, the box will be there just where I need it.

Afterword

If there is 'proof' that this project carries resonance, it is that it is completely sold out and that so many people supported the project to begin with. OiE raised its funds that allowed for its later printing through Kickstarter, exceeding its original goal by two-fold in two days with almost 500 backers. The frequency at which backers were eager to purchase this project reflects the urgent need for more projects like this.

This thesis discussed larger issues of unwellness and care by focusing on OiE as an intervention alongside attending to the historical contexts of the psy-disciplines, biomedical accounts of suffering, and wellness movements. At the end of my interview with Khúc, I had asked her what she hoped for. I now want to turn the question to myself. I hope to see further analyses of the ways in which narrow definitions of wellness gets enacted, further analysis of the ways it gets tied in with economic forces of what products are poised to be most profitable, further analysis in the ways wellness is just another conduit for power and exclusion to operate. I also hope to see more work on the ways universities are responding to student unwellness, the ways university stakeholders are listening (or not) to student accounts of what they need, the faculty voices in the room (and the disciplines that they reflect) when discussing student unwellness. I hope to grapple with how surveillance is increasingly being used within this broader landscape of wellness such as through student

of concern reports.[1] Surveillance is not immediately a *de facto* good or bad, but it does need to be problematized and complicated in relation to the ways of knowing who counts as a student of concern and why they might be seen as such.

Finally, I also hope to see more resources developed that challenge those in power (located in biomedicine and in the academy) to think through notions of care and unwellness differently, in political, vulnerable, sometimes uncomfortable ways, and especially in ways that move beyond just a biomedical framework. I hope to see more survival tools developed by community members whose lived experiences of differential unwellness are seen as meaningful and imperative to justice work. What if wellness centers also talked about institutional oppression alongside promoting meditation and yoga? What if universities, students, and faculty members go "beyond Squeezable Stress Stars" as an approach to mental health on campus?[2] To do so, I argue, would seriously break open, trouble, and reveal room for even greater possibility.

Footnotes

Introduction

[1] It must be noted that "Asian" and "Asian American" is a broad and diverse category. There is a lot of contention and politics over what the "Asian American" identity and the category of "Asian" might mean. The image of "Asian" also can evoke an image of a particular type of person, such as East-Asian people, often to the exclusion of South and South-East Asians and Pacific Islanders. This is especially important to consider given East Asia's own colonialist history (such as China's colonialism in Vietnam and Japan's colonialism in South Korea and various areas in Southeast Asia). A little bit to the left is a contribution from Nina Kaur, who is writing on Sikhphobia. Words like "ISIS," "Suicide Bomber," and "Terrorist" are included. These words can be taken almost in direct contradiction to the "passive, overly dependent, quiet" image evoked by Kawamoto. It would be a big critique to the OiE project if the only representations of "Asian-Americans" involved East Asians. However, AALR was able to include representations of Asian-Americans beyond just East Asian-Americans, reflecting the diversity of the contributors and the diversity of what Asian-American means. See Lisa Lowe's *The Intimacies of Four Continents* on Asian racialization and settler colonialism and David L. Eng and Shinhee Han's *A Dialogue on Racial* Melancholia in *Psychoanalytic Dialogues* (2000). The rest of the thesis will use "Asian American" as an identity category, with the recognition that the label is not homogenous or apolitical by any means.

[2] The issue of university mental health care systems — and the care gap between what university systems have and the increasing demand by students — has gotten increased amounts of attention. What I will argue is that the narratives of this mental health crisis, while needing to be taken into consideration, ignores a lot of the more nuanced landscape of mental health on college campuses and the differential contours that shape unwellness as OiE defines it.

[3] Merle Woo's *Letter to Ma* appears in *This Bridge Called My Back,* a greatly influential anthology of radical women of color. Woo's writing is among several Asian-American women's writings included in this anthology.

[4] For the link to the Kickstarter campaign, please see the link: https://www.kickstarter.com/projects/1750978990/asian-american-tarot-a-mental-health-project?ref=nav_search&mc_cid=b875427629&mc_eid=00db090992

[5] See the OiE page on AALR's website for more information: https://aalr.binghamton.edu/special-issue-on-asian-american-mental-health/

[6] See the 'news coverage' tab for OiE on AALR's homepage: https://aalr.binghamton.edu/

[7] For an extensive account of the Mad liberation movement, please see Linda Morrison's *Talking Back to Psychiatry: The Psychiatric Consumer/Survivor/Ex-Patient Movement*.

[8] For further critique of the DSM-III as a turning point that codified the DSM as having "objective" biomedical expertise, see Mitchell Wilson's "DSM-III and the Transformation of American Psychiatry: A History" (1993).

[9] For example, race and culture need to be further attended to in critical discussions of anti and critical psychiatry, as well as in Mad studies. See Jonathan Metzl's *The Protest Psychosis: How Schizophrenia Became a Black Disease*. For further essays on intersectional approaches to madness and race, see *Mad Matters: A critical reader in Canadian Mad studies* (2013).

[10] The term, "Debt-bound daughter" comes from erin Khuê Ninh's book, *Ingratitude: The Debt-Bound Daughter in Asian American Literature*. Ninh analyzes a type of subject formation that is not "exclusive to, but racially and gender-specific to, second generation Asian American daughters" (Ninh, 11), one that, "through modes disciplinary and discursive…perpetually [produces] the unfilial subject—caught in a system of 'designated failure'" (Ninh 16). Ninh's work is one of the books that changed my life, as she traces how a family's commitment to capitalist ideals produces children to be good capitalist investments, in efforts to pay off the family's suffering and sacrifice.

[11] In many Asian-American communities, there is a deep stigmatization of mental health. The rhetoric in immigrant families, especially, center on how parents overcame their struggles, which are interpreted as being more difficult and significant than their children's, to get to where they are.

[12] There is a growing wealth of scholarship on workplace wellness programs. See Julie Passanante Elman's article, *"Find Your Fit":Wearable technology and the cultural politics of disability* and L. V. Anderson's Slate article, *Workplace Wellness Programs are a sham*.

[13] The concept of "self-care" was reignited by Audre Lorde in her book, *A Burst of Light: Living with Cancer*, with her famous quote, "Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare" (Lorde, 1999).

Unwellness

[1] Fortune.com reports that Goop is now valued at $250 million. At the time of writing this thesis in late February 2019, Netflix signed a series contract with Paltrow. See http://fortune.com/2018/03/30/gwyneth-paltrow-goop-series-c-valuation-250-million/ and https://www.vox.com/2019/2/7/18215395/netflix-gwyneth-paltrow-series-goop-pseudoscience. I draw in Paltrow's company in particular to draw attention to the wellness industry and the types of wellness/health that it sells. Paltrow's pseudoscientific claims about health is an additional dimension to the problematics of this company, but will not be talked about in this thesis, though it would make for interesting analysis.

[2] Google Ngram is a program that allows the user to see the frequency of words through how often they were published in books. It generates a timeline of when and to what frequency certain books were used. The limitations of this, of course, is that it only includes published books that are cataloged through Google Books. Nevertheless, a quick use of Google Ngram is still an interesting tool to gather at least a quick landscape of some terms in particular.

[3] The *60 Minutes* video can be found here: [https://www.youtube.com/watch?v=LAorj2U7PR4]

[4] See Barbara Ehrenreich's critique of positive thinking: *Bright-sided: How the relentless promotion of positive thinking has undermined America* (2009).

[5] See Adrienne Rich's *Compulsory Heterosexuality and lesbian existence* (1980).

Design

[1] For further reading on hacker culture and its history and relationship to internet and computers, see Douglas Thomas's book, *Hacker Culture*.

[2] The DSM has a long history of pathologizing those in LGBTQ communities. For instance, between 1952 and 1973, homosexuality was listed as a mental disorder (though in the 1973 edition it was changed to "Sexual Orientation Disturbance") (Price, 2011). The DSM V still lists "gender dysphoria" and "transvestic disorder" (http://www.thetaskforce.org/invalidating-transgender-identities-progress-and-trouble-in-the-dsm-5/).

Pedagogy

[1] Margaret Price's deeply moving book, *Mad at School: Rhetorics of Mental Disability and Academic Life*, skillfully analyses how academic discourse intersects with discourse around mental disability. My friend does not have a mental disability, but I use this example here to foreground the importance of recognizing that students and faculty's experiences in higher education are inflected by differential unwellness, however that might manifest and for however long. This section asks what do we do with this recognition that, in Khúc's words, "we are all differentially unwell" and how might it inform pedagogy?

[2] As but one example, Georgia Tech launched a mental campaign, in which GATech's president remarked that some members of this "family" were struggling and that in response, they should use some of these "available resources", which was followed by "professors that you can talk to". The link to the video campaign can be found here: [https://twitter.com/georgiatech/status/1070341898412408832?lang=en]

[3] See https://www.chronicle.com/article/Professors-Are-Talking-About/243353

[4] See Vanderbilt News for articles about Vanderbilt students being ranked as the "happiest students": https://news.vanderbilt.edu/2017/08/01/vanderbilt-has-happiest-students-again-according-to-2017-princeton-review-best-colleges-rankings/. Additionally, several students have remarked to me that because of this label, they feel pressure to embody what it means to be the "happiest student." In recent years, Vanderbilt has launched many mental health campaigns that try to encourage students to seek mental health support and has established centers that are aimed for student wellness. However, some students have remarked that they feel as if these resources are not for them, whether it's because they do not know about it or feel alienated from seeking support there.

[5] See https://vanderbilthustler.com/campus/reflecting-on-the-center-for-student-well-beings-first-three-months.html for brief background information on the Center.

[6] To my understanding, Vanderbilt had cut portion sizes to be more in line with "recommended portions" because Campus Dining "cares significantly for the health" of Vanderbilt students.

[7] The construction here referenced refers to large swaths of construction that's been happening as part of the "Future VU" project on Vanderbilt's campus. As some students have critiqued, in Hamraie's Designing Healthy Publics class, Vanderbilt only cares about the future students instead of the present students currently on campus.

Conclusion

[1] See Vanderbilt's student of concern report here:

[https://cm.maxient.com/reportingform.php?VanderbiltUniv&layout_id=4]

[2] See Jay T. Dolmage's critique of university mental health programs that do not address the underlying structural issues at play: https://philosophycommons.typepad.com/disability_and_disadvanta/2018/08/beyond-squeezable-stress-stars-mental-health-on-university-campuses-guest-post.html

Appendix

Figure 1. Questions and student answers relating to "What is care/wellness/unwellness?"

Care:	**Wellness**	**Unwellness**
-Community	-Do not need to rely on others	-Lack of control
-Time	-Feel good about self	-Surveillance (parents, social media)
-Dealing with stressors	-Self-care	-Bed-ridden
-Self-reflection	-Potential	-Isolated/lonely
-Open/honest	-Physical health	-Marketing
-Intentionally unproductive	-Norms	
	-Being productive	
	-Independent, functional	
	-Having a social network	
	-Can cope with everyday stresses	
	-Good mental health	

Figure 2. Screenshot of a "Map of Unwellness"

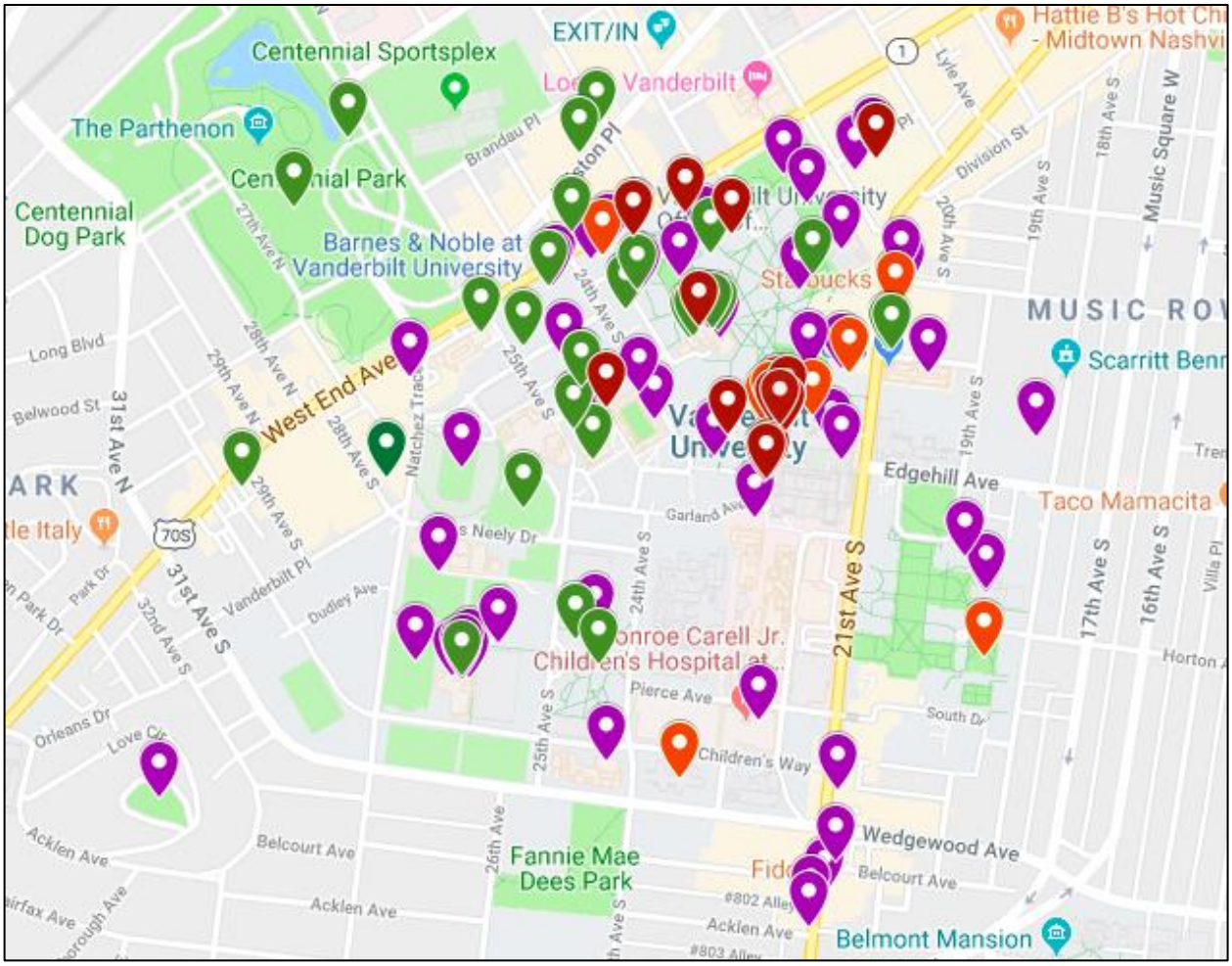

Image description: screenshot of a map of Vanderbilt University's campus with colorful pins dropped to indicate specific locations. Green pins indicate where students feel cared for, purple pins indicate where students feel well, orange pins indicate where students feel unwell, and red pins indicate where students do not feel cared for. Some pins are densely congregated in one area of campus while others are spread across. Link to the map itself (which includes student comments) can be found here [https://drive.google.com/open?id=1L0OzWMwlrIXwmD2InW26dHmH_-j1ZG36&usp=sharing]

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